Authorization for Medical Care and Recognition and Assumption of Risk Agreement

This authorization covers _____ during his/her travel to and participation in _____. This activity covers the period _____ through _____.

I, the undersigned parent or person or the legal guardian of the above-mentioned 4-H member, authorizes their participation in the listed event. In giving this consent I recognize and understand that precautions will be taken to safeguard the health and welfare of all who attend. However, in consideration of allowing said child to attend and participate in this activity, it is my understanding that participation in the activities that make up this event are not without some inherent risk of injury. As such, in consideration of my child's participation, I do hereby release, waive, discharge, and covenant to not sue the event, its organizers, the Oklahoma 4-H program, Oklahoma State University, Langston University, the Oklahoma Cooperative Extension Service, the State of Oklahoma or their officers, servants, agents, or employees and release them from any liability, claims, demands, and causes of action whatsoever arising out of or related to any loss, damage, or injury including death, that may be sustained by my child while participating in such activity, or while in, on, or upon the premises where the activity is being held (the provisions of the Oklahoma Governmental Tort Claims Act not withstanding).

In giving this consent I recognize and understand that in situations where the above named minor requires immediate medical or hospital care it may not be possible to contact me, and that in such situations I will not be able to knowledgeably evaluate and choose among the available alternative treatments or procedures, if any, or to evaluate the risks attendant upon each, and the risks attendant to foregoing all treatment; in such situations, I authorize a physician, surgeon or dentist to exercise his professional judgment and assess the risks incident to and choose the necessary treatment from any available alternatives and to render such care and perform such treatment as he in his professional judgment determines to be necessary for the health and safety of the above named minor. I furthermore understand that a medical insurance policy carried by _____, if any, will provide only minimum coverage and that I will be responsible for costs associated with the care and treatment of the above-mentioned child.

CONTACT INFORMATION

Work Phone ( ) _____ Home Phone ( ) _____
Cellular Phone ( ) _____ E-mail _____
Address _____ County _____
City _____ State _____ Zip Code _____
Family Medical Insurance Company _____
Policy Number _____ Policy Holder's Name _____

TREATMENT INFORMATION

Delegate's Birth Date _____ SS # _____ Gender _____
Delegate's Allergies _____
_____
Family Doctor _____ Phone ( ) _____
Other Doctor _____ Phone ( ) _____
Medicine delegate is taking _____
_____
Date of Delegate's last Tetanus Shot _____
Delegate's Medical History (diabetes, asthma, etc.)
_____

If the delegate has a serious medical condition or is under a doctor's care, a letter from the doctor should be attached outlining the nature of the condition, treatment or medical history.

I ACKNOWLEDGE that I have been provided a copy of the Notice of Health Information Practices as outlined in 45 CFR 164. I further acknowledge that this is general information and that I will be asked to acknowledge specific information by the provider.

If emergency personnel are unable to locate the individual(s) listed above, and the minor cannot provide self-consent, the minor who presents with an urgent problem shall receive treatment as necessary at the discretion of the physician on duty.

PARENT'S SIGNATURE:_____ Date _____
(of parent or person having legal custody or legal guardianship)

DELEGATE'S SIGNATURE: _____ **WITNESS** _____